American Urogynecologic Society

Advancing Female Pelvic Medicine and Reconstructive Surgery

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December 3, 2010

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-NC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Delivered Electronically

Re: Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program; 75 *Fed. Reg. 70,165* (November 17, 2010); CMS-1345-NC.

Dear Dr. Berwick:

On behalf of the American Urogynecologic Society (AUGS), we are pleased to submit information in response to the Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program; 75 *Fed. Reg. 70,165* (November 17, 2010); CMS-1345-NC. AUGS is a national medical society whose mission is to promote the highest quality of care in female pelvic medicine and reconstructive surgery through excellence in education, research and advocacy.

In the request for information, the Centers for Medicare and Medicaid Services (CMS) seeks comments on how it can "advance ACO structures that are organized in ways that are patient-centered and foster participation of physicians and other clinicians who are in solo or small practices." CMS asks several important questions about what policies or standards it can develop to achieve these goals, including ensuring that small practices have access to "capital or other resources to fund efforts from which 'shared savings' could be generated." Having reviewed these questions posed by CMS, AUGS would like to share the following comments for consideration by CMS as it develops its proposal to implement the Accountable Care Organization (ACO) and the Shared Savings Program.

- **To allow small practices to participate in an ACO,** CMS needs to recognize that specialists, such as urogynecologists, do the work of three physicians for most of their patients with pelvic floor disorders – the gynecologist, urologist, and colorectal surgeon. The structure of the ACO needs to recognize this and also not impede on this physician-patient relationship by narrowly defining the role of the specialist in providing patient care. For women with pelvic floor disorders, urogynecologists are the "medical home," able to best coordinate any care needed from additional specialties physicians in taking care of pelvic floor disorders. Our expertise enables a

"step ladder" approach to taking care of patients offering the most conservative therapies firsts and then moving up the ladder to more aggressive surgery, when needed.

- **Small practices have become very adept in how they use midlevel providers to perform patient education and coordination of care**. This model needs to be preserved in any ACO demonstration program and compensated appropriately through coordination bonus payments or additional patient management fees.

- **Small practices need to be able to participate with more than one ACO**. All ACOs need to have access for patients to the entire complement of specialists. For access to urogynecologists, this means that one group of urogynecoligists may need to be working with numerous ACOs in their region or area. Access to only a general gynecologist or a general surgeon is not considered access to appropriate care for women with pelvic floor disorders.

- **Regarding different ways to structure payment models, payments should be based on risk-adjusted patient outcomes.** ACO participants should be encouraged to use their achieved savings to support data collection into specialty specific registries for the purpose of developing outcomes measures. Registries such as NSQIP have been valuable to hospitals in assessing patient outcomes. Providing this type of registry as well as support for specialty specific registries and having participation be part of the ACO program would help move the health care delivery and payment system to an outcomes-based system, not a process-based system. Surgical specialty specific registries can also support the risk-adjustment that these payment models need to incorporate to be successful.

- **Monthly patient management fees or other enhanced payment structures, in addition to current Medicare fee-for–service reimbursements, should be instituted under the ACO program.** These monthly payments would support better coordination of patient care, patient education, group counseling sessions, at home support and other patient care services that are not currently reimbursed under the Medicare physician fee schedule, but shown to enhance patient care and satisfaction, leading to better outcomes.

- **Regarding patient satisfication, ACOs should use satisfaction questionnaires that have been scientifically validated and can be answered by both patients and providers.** These questionnaires should be used to set expectations for the patient at the entry point into the ACO and then at certain intervals to allow for ongoing collection of patient satisfaction outcomes. Much of a patient satisfaction is determined by that patient's expectations when they enter the care delivery system and ACOs need to establish processes to support physicians in discussion with their patients to outline appropriate care plans and pathways for that patient's condition and its severity.

- **Regarding additional payment models, specialists within ACOs delivering the highest quality of care, weighted by a patient's risk factors, should be rewarded.** Specialists within an ACO referred the most difficult cases should not be compared to generalists doing the primary or less complicated cases. The advantages of payment models that reward physicians based on the complexity of the patient they are treating is that all patients will have access to appropriate care. The disadvantages are that physicians less able to treat difficult patients may have a financial incentive not to refer them. Ensuring that as part of an ACO's application submission there is a plan regarding how the ACO will encourage appropriate referral through their use of patient satisfaction measures, patient outcome measures, and other processes will be important to the success of this demonstration project.

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AUGS looks forward to working with CMS to discuss and work on together these important issues. If AUGS can provide CMS with additional information, please do not hesitate to contact Michelle Zinnert at 202-367-1235 or michelle@augs.org.

Sincerely,
Roger Goldberg, MD
Chair, Health Policy Committee